Rosh Health Center
info@roshhealth.com
www.roshhealth.com

Authorization to Disclose Protected Health Information

Patient Name: _____ DOB: _____/ _____/ _____

Phone: _____-_____ Address: _____

As required by the privacy regulations, Rosh Health Center healthcare providers may not use or disclose protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize: _____

Address: _____
Street Number City State Zip

Reason to release protected health information: _____

Type of access requested (copies of the records):

☐ Entire record	☐ Nursing notes	☐ ER records
☐ Imaging/radiology	☐ History and physical	☐ Consult reports
☐ Operative reports	☐ Rehabilitation services	☐ Immunizations
☐ Laboratory reports	☐ Cardiac studies	☐ Demographics
☐ Progress notes	☐ Physician's orders	
☐ Medication records	☐ Other_____	_____

- I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.
- I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that there may be a fee involved with the fulfillment of this request.
- I understand that the term, entire record, regarding release of protected health information means that only records generated by the named facility will be released.
- I have read the above and authorize the disclosure of the protected health information.

_____ _____/ _____/ _____
Signature of Patient or Legal Guardian **Date of Signing**

_____
Signer Name if Legal Guardian (Please Print)